UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Pegasys & PegIntron

Patient name:_____Medicaid or SS#_____

Physician Name:_____Contact person_____

Phone#:_____Ext. and Opt._____Fax#_____

Pharmacy_____Pharmacy Phone#_____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO (801) 536-0477

CRITERIA:

Documented diagnosis of Hepatitis C

AUTHORIZATION:

Authorization will be given for one 48-week supply.

RE- AUTHORIZATION:

Coverage may be extended to 72 weeks in patients with a documented late viral response (defined as failure to clear the virus until weeks 12-24 of treatment).